MASSACHUSETTS DEPARTMENT OF INDUSTRIAL ACCIDENTS
DIA TRUST FUND M.G.L. c. 152 § 34B(c) COLA REIMBURSEMENT REQUEST FORM
PAYMENT QUARTER _____ / _____ / _____ TO _____ / _____ / _____

For assistance in completing this form please see page 2 for directions.

A	B	C	D	E	F	G	H	I	J	K	L
DIA Board #	Claimant & Employer Names	Claimant's Address	Claimant's Social Security #	Date of Injury	Date of Eligibility for Benefits	Weekly Compensation (Base Benefits)	COLA Mulitplier (POST 10/1/86 ONLY)	Weekly Adjustment Paid (Supplemental Benefits)	Total Weekly Compensation Paid	# of Weeks Paid	Reimbursement Due

Total Reimbursement Due _____

NOTE: A signed COLA Cover Sheet and all supporting documentation must accompany this form to be considered for reimbursement.

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DIRECTIONS

NOTE: The Workers' Compensation Trust Fund will only reimburse *Insurers* for COLA payments.

A. Please make sure that the correct Board Number is in this column.
B. Be sure to include both parties.
C. This is the address at which the employee/widow recieves payment.
D. Include claimant's social security number.
E. Date of injury as stated on the Form 110.
F. For § 31 (Widow Benefits) the date for this column is the date of the employee's death. For § 34A (Permanent and Total Incapacity Benefits) the date for this column is the date of injury.
G. The base benefit is equal to the amount ordered to be paid to the employee/widow on a weekly basis.
H. See current circular letter for appropriate § 34 adjustments, multipliers and reimbursement factors.
I. Supplemental benefit is equal to the Base Benefit times the COLA multiplier minus the Base Benefit.
J. Total amount paid to employee/widow per week. This number should be the Base Benefit plus the Supplemental Benefit.
K. Total number of weeks in the quarter in which a payment was made to the employee/widow.
L. The amount to be reimbursed to the Insurer will be equal to the Supplemental Benefit times the number of weeks paid in the quarter.

SUPPORTING DOCUMENTATION:

- The COLA request form must be accompanied by a signed COLA Cover Sheet.
- Proof of Payments – Insurers must provide an indemnity record of what has been paid out. This will also ensure that the request has been made in a timely fashion.
- Proof that Payments were Proper –
    - The Insurer will be required to submit a copy of the order, decision or agreement for each case it wishes to be reimbursed on.
    - The Insurer must sign the COLA Cover Sheet under the pains and penalties of perjury, and therefore should complete an CR-28 form with the Social Security Administration to ensure that the COLA payments were in fact not offset by SSA payments.
    - For § 34A claims the Insurer must also submit recent medicals on the employee, thereby backing up the statement of permanent and total disability.

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PAYMENT QUARTER _____ / _____ / _____ TO _____ / _____ / _____

FROM:

_____
_____
_____
_____

Mail To:

COLA Processing_____
DIA Office of General Counsel
600 Washington Street, 6th Floor
Boston, MA 02111

Attached please find a request, pursuant to M.G.L. c. 152 § 65, for Cost of Living Adjustment (COLA) reimbursements for COLA's paid on behalf of _____ claimants totaling $_____. This request is being submitted on behalf of _____ Insurer.

I hearby certify under pains and penalties of perjury that all laws of the Commonwelth of Massachusetts governing assessments and regulations thereof have been complied with and observed, and that all information is, to the best of my knowledge, correct. I hereby certify that there is no pending litigation in any of the named cases, that there is no payment being made by the Social Security Administration in the named cases that would affect eligibility for supplemental COLA benefits, and that the employer(s) named have not chosen to opt-out pursuant to M.G.L. c. 152.

Signed: _____
Name: _____
Title: _____
Organization: _____
Phone #: _____
Date: _____

FOR INTERNAL USE ONLY

Comments:

Payment Approved: _____

Date: _____